ARRA RECOMMENDATIONS FOR HEALTH IT "MEANINGFUL USE"

May 13, 2009

RECOMMENDATIONS – QUALIFIED SYSTEMS

As Presidents Bush and Obama both have said, the end goal is for all Americans to have an electronic health record, not for all American institutions to have one.

It is clear from the legislative language that what is required for electronic health records is first and foremost a record (not multiple records) "on an individual". That record must have the capacity to provide clinical decision support and physician order entry; capture and query information relevant to health care quality; and exchange with and integrate data from external sources.

The definition does not require that the electronic record be able to run a physician practice or hospital.[1]

Implementing regulations for the definition of `qualified electronic health record' should incorporate what we know about what works and what doesn't work:

- an electronic record "on an individual"– the technology should be capable of creating, or be part of a system capable of creating, a single clinical record on individual patients designed to support the care of each such individual. As the new HIPAA requirements in the bill make clear, the individual must have access to and control over this record and must have the ability to control the access of others.

- that record must have the capacity to provide

    - clinical decision support;
        - to do decision support competently, the technology must be able to understand and utilize relevant data from both internal and external sources in a form that (a) persists and (b) can be used in real time to execute rules, analyses and such other tools necessary to provide effective decision support;

    - physician order entry;

    - for the capture and querying of information relevant to health care quality;

[1] The Department should make clear that the records for which funding is being provided are systems to support care of individuals and not necessarily systems designed primarily for running institutions or practices that have as an ancillary function the display of electronic data related to a patient held by that system. This is an important distinction and fulfills the goal of federal investment in health IT championed by President Obama.

- to support improved care quality, the technology must have the same capabilities as described above for clinical decision support;

- for exchange of patient data with and integrate data from external sources.
    - To be most effective, the regulations should require that the external information be integrated and represented to the user, and capable of understanding and use, in the same manner as the internal data

- Because access to and control over the record lies with the patient under the new HIPAA requirements, the same record can be used to support patient compliance and self-care to " (9) promote[ ] early detection, prevention, and management of chronic diseases"; – this should not depend on when or where care is provided or where the record is hosted.

- The record must be persistent. Without this requirement in regulations, privacy and security cannot be assured and the data are repudiatable. They therefore cannot be depended on for care, undermining the quality of clinical decision support, evidence-based medicine rules, and other ancillary services. The regulations should require that the same single persistent record be used by the patient and all the patient's caregivers.

In addition, the regulations should make clear that payments for access to or use of such records, including access through Web technology, are eligible spending. Actual purchase of hardware or systems for managing a practice or hospital should not be a requirement and should, in fact not be considered as qualifying unless the criteria relating to the support of individual care are met.

Certification must have teeth or it becomes the weak link that can fail and reduce the potential of the technology investment. New certification categories, linked to capabilities and functions rather than site of deployment, should be developed.

RECOMMENDATIONS –"MEANINGFUL USE"

For use "in a meaningful manner", a provider should be required to demonstrate:

- regular use of a patient-centered record such as that described herein, including provision for patient access and control;
- improved care quality for individual patients through the use of accepted measures

To the extent that providers with existing EHR systems do not already have these capabilities, they must develop them no later than the end of the first reporting year.

Meaningful use should be related to the impact of health IT use on care quality and safety. It should not measure only processes. The Department should examine what clinical measures may be developed that can be best related directly to use and are susceptible to documentation requirements.

It is hard to over-emphasize the importance of this criterion. If we are confined to measuring institutional processes alone, then we shall have a misaligned system of incentives and rewards. This misalignment will result in systems that are neither useful nor usable and the IT will block rather than promote health care innovation. Experience has shown this on many occasions, with absurd consequences.[2]

Contacts:

Ralph Korpman, MD, 951.453.9329, ralph.korpman@centrihealth.com

Charles Kennedy, MD, 805.217.6724, charles.kennedy@wellpoint.com

Susan Christensen, 703.489.2284, schristensen@bakerdonelson.com

[2] The great danger is that an IT-based definition of "Meaningful Use" based on exclusively institutional measures will result in a huge bureaucratic system that requires detailed reporting of many parameters, but that has lost touch with the hoped for benefits to Americans. There is direct experience of such systems in the English NHS.

For example, one measure of access/usage was every hospital specialist's desk should have on it a computer system. Institutions (hospitals etc) were set percentage targets for the specialist's desks covered. Even if one believes this makes any sense as a measure of value to patients, things soon devolve into gaming around the definition of "desk". Some places actually removed or redefined "desk" in order to raise the percentage, while others assigned multiple specialists to a single desk to achieve high figures. Meanwhile the doctors who didn't have a "desk" (because they spent their time on the wards where the patients were to be found in beds), didn't count at all in some places or unwanted desks were bought for others. And so more detailed definitions appeared, and so on and so, while nothing useful happened.